STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted from 5/11/21 to 5/13/21. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID #SWBW11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 05/11/2021 through 05/13/2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# SWBW11. 1 of the 8 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		5/31/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/31/2021

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F 657	Continued From page 1 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and observations, the facility failed to update the care plan to address a cognitively impaired resident' s refusal to be bathed daily for 1 of 1 cognitively impaired resident's reviewed. (Resident #3) The findings include: Resident #3 was originally admitted to the facility on 8//27/19 with diagnoses including diabetes mellitus without complications, heart failure, unsteadiness on feet, Alzheimer's Disease with early onset, hypertension, chronic kidney disease stage 3, dementia without behavioral disturbance and cerebral infarction without residual side effects. According to the most recent Minimum Data Set (MDS) dated 4/7/21, Resident #3 was cognitively impaired, required supervision to independence for some activities of daily living and physical assistance with bathing. A nursing note dated 4/21/21 at 1:08 PM read "Resident #3 was given a total bath after her family member and another family member talked to her via telephone."	F 657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice This resident #3 care plan was updated on 5-13-2021 to include refusal for bathing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents with cognitive impairment have the potential to be affected. A 100% audit of care plans for cognitively impaired residents was completed by the MDS Nurse for the potential to refuse bathing. 53 residents were identified as having the potential to be affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 657	Continued From page 2 A nursing note dated 5/11/21 at 7:36 PM, read, "Resident #3 let Certified Nurse Aide (CNA) do personal care during shift. Resident was compliant with care. Resident #3 thanked CNA for personal care being done." Bathing report for April: 4/1/21-4/30/21 7 baths given, 3 partial baths given, 6 baths refused, 4 no bath given, and 10 baths undocumented. Bathing report for May: 5/1/21-5/13/21, 5 baths given, 3 partial baths given, 1 no bath given and 2 baths undocumented. Shower report for April: 4/1/21-4/30/21, 5 showers given, no shower given for week 4/5/21-4/11/21, 1 partial shower and 1 shower refused. Shower report for May: 5/1/21-5/13/21 3 partial showers given. During an interview on 5/11/21 at 9:38 AM, Resident #3's family member stated she talked to the Social Worker, Administrator, Director of Nursing and a Nurse and was told Resident #3 refused to get a bath and that Resident #3 washed herself. The family member revealed that she was also told that Resident #3 had the right to refuse to take a bath. Resident #3's family member revealed Resident #3 was not capable of taking care of herself. During an interview on 5/11/21 at 10:40 AM, Nurse Assistant (NA#1), who worked with Resident #3 on first shift, stated she set Resident #3 up with a washcloth and a bath basin in the morning. She said Resident #3 could wash herself, but she needed assistance. She said	F 657	reoccur Education was initiated on 5-26-2021 for Licensed staff to include agency staff for updating care plans to address a cognitively impaired resident□s refusal to be bathed. Newly hired employees to include agency will be educated during orientation regarding care plan updating. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Clinical review for each previous 24-hours will be brought to the daily clinical meeting by the unit manager. Records will be reviewed by the Clinical Team to include Unit Manager, Director of Nursing, Social Services, and Rehabilitation to ensure refusal of bathing is addressed in the care plan. The minutes from the meeting will be reviewed by the Director of Nurses 3 times per week for 4 weeks then weekly for 4 weeks, then monthly for 1 month. The Administrator will review and initial the daily clinical minutes weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the clinical minutes tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	

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F 657	Continued From page 3 Resident #3 tried to be as independent as possible and she would often refuse baths. NA #1 stated if Resident #3 refused bathing, she would step out of her room and come back and ask her again. She stated she would notify the nurse if she continued to refuse. NA#1 said she just started working with Resident #3 yesterday. She said she had worked with Resident #3 once or twice in the past. She said she offered Resident #3 showers, but she often refused them. She said she also refused bed baths. She stated 3:00 PM to 11:00 PM shift could sometimes get Resident #3 to get in the shower at night. She stated when Resident #3 refused baths, she reported it to the nurse. During an interview on 5/11/21 at 4:00 PM, Nurse Assistant (NA#2), who worked with Resident #3 on second shift, stated Resident #3 got a shower on day shift. She revealed Resident #3 often resisted taking showers. She stated occasionally Resident #3 got a shower at night. She stated Resident #3 was fine if she did not have to take a shower or bath. During an interview on 5/13/21 at 1:36 PM, the Director of Nursing revealed that Resident #3's care plan would be revised to address Resident #3 ' s non-compliance with bathing. During an interview on 5/13/21 at 2:35 PM, the Administrator revealed the care plan should address the resident's right to refuse bathing and if the resident refused, her expectation would be that the staff would continue to offer the bath again.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		5/31/21

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F 677	Continued From page 4 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and observations, the facility failed to provide bathing assistance daily to a cognitively impaired resident for 1 of 1 cognitively impaired resident's reviewed. (Resident #3) The findings include: Resident #3 was originally admitted to the facility on 8//27/19 with diagnoses including diabetes mellitus without complications, heart failure, unsteadiness on feet, Alzheimer's Disease with early onset, hypertension, chronic kidney disease stage 3, dementia without behavioral disturbance and cerebral infarction without residual side effects. According to the most recent Minimum Data Set (MDS) dated 4/7/21, Resident #3 was cognitively impaired, required supervision to independence for some activities of daily living and physical assistance with bathing. A nursing note dated 4/21/21 at 1:08 PM read "Resident #3 was given a total bath after her family member and another family member talked to her via telephone." A nursing note dated 5/11/21 at 7:36 PM, read, "Resident #3 let Certified Nurse Assistant (NA) do personal care during shift. Resident was compliant with care. Resident #3 thanked NA for personal care being done."	F 677	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The Resident #3 was provided a bath on 5-24-2021. The care plan was updated to address what happens when the resident refuses bathing. Facility will allow the resident to make decisions about treatment regime, to provide a sense of control by encouraging participation, providing clear explanation during each contact, negotiate a time for bathing, if resident resists with bathing reassure resident, leave and return at a later time ad provide resident with opportunities for choice during care. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents with cognitive impairment have the potential to be affected. A 100% audit of care plans for cognitively impaired residents was completed by the MDS Nurse for the potential to refuse bathing. 53 residents were identified as having the potential to be affected by this deficient practice. Care plans were updated to provide specific interventions to address	

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F 677	Continued From page 5 Bathing report for April: 4/1/21-4/30/21 7 baths given, 3 partial baths given, 6 baths refused, 4 no bath given, and 10 baths undocumented. Bathing report for May: 5/1/21-5/13/21, 5 baths given, 3 partial baths given, 1 no bath given and 2 baths undocumented. Shower report for April: 4/1/21-4/30/21, 5 showers given, no shower given for week 4/5/21-4/11/21, 1 partial shower and 1 shower refused. Shower report for May: 5/1/21-5/13/21 3 partial showers given. Resident #3's care plan dated 4/7/21 revealed the care plan was not updated to address Resident #3's refusing to be bathed. During an interview on 5/11/21 at 9:38 AM, Resident #3's family member stated she talked to the Social Worker, Administrator, Director of Nursing and a Nurse and was told Resident #3 refused to get a bath and that Resident #3 washed herself. The family member revealed that she was also told that Resident #3 had the right to refuse to take a bath. Resident #3's family member revealed Resident #3 was not capable of taking care of herself. During an interview on 5/11/21 at 10:40 AM, Nurse Assistant (NA#1), who worked with Resident #3 on first shift, stated she set Resident #3 up with a washcloth and a bath basin in the morning. She said Resident #3 could wash herself, but she needed assistance. She said Resident #3 tried to be as independent as possible and she would often refuse baths. NA #1 stated if Resident #3 refused bathing, she would	F 677	the needs of the residents in the event refusal of bathing occurs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Education was initiated on 5-26-2021 for Licensed staff to include agency staff for updating care plans to address a cognitively impaired resident's refusal to be bathed and documentation for bathing. Newly hired employees to include agency will be educated during orientation regarding care plan updating. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Clinical review for each previous 24-hours will be brought to the daily clinical meeting by the unit manager. Records will be reviewed by the Clinical Team to include Unit Manager, Director of Nursing, Social Services, Rehabilitation to ensure refusal of bathing is addressed in the care plan and documentation is complete for the care provided to residents. If refusals are identified the Director of Nurses will review the interventions and update the plan of care as indicated for individual needs. The minutes from the meeting will be reviewed by the Director of Nurses 3 times per week for 4 weeks then weekly	

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F 677	Continued From page 6 step out of her room and come back and ask her again. She stated she would notify the nurse if she continued to refuse. NA#1 said she just started working with Resident #3 yesterday. She said she had worked with Resident #3 once or twice in the past. She said she offered Resident #3 showers, but she often refused them. She said she also refused bed baths. She stated 3:00 PM to 11:00 PM shift could sometimes get Resident #3 to get in the shower at night. She stated when Resident #3 refused baths, she reported it to the nurse. During an interview on 5/11/21 at 4:00 PM, Nurse Assistant (NA#2), who worked with Resident #3 on second shift, stated Resident #3 got a shower on day shift. She revealed Resident #3 often resisted taking showers. She stated occasionally Resident #3 got a shower at night. She stated Resident #3 was fine if she did not have to take a shower or bath. During an interview on 5/13/21 at 1:36 PM, the Director of Nursing stated her expectation regarding bathing was that in-services would be provided on bed baths and showers. During an interview on 5/13/21 at 2:35 PM, the Administrator revealed residents have the choice to refuse baths. She stated her expectation would be for the bath to be offered again if the resident refused.	F 677	for 4 weeks, then monthly for 1 month. The Administrator will review and initial the daily clinical minutes weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the clinical minutes tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	